

## APPLICATION FOR CHILD AND YOUTH MENTAL HEALTH SUPPLEMENTARY SERVICES

---

### PROGRAM REQUESTED:

☐ Respite Services      ☐ Supportive Case Management      ☐ Intensive Case Management      ☐ Home and Community-Based Services Waiver

**Referrals for Community Residences and/or Residential Treatment Facilities must also be approved by the Single Point of Entry Committee. For information, please call (518) 792-7143.**

---

### CLIENT INFORMATION:

Name:                      DOB:                      Date of Referral:

Address:                      City, State, Zip:

Phone (Home):                      Phone (Cell/Work):                      Sex:

Social Security #:                      Medicaid/Medicare #:                      Other Insurance:

Mother (include name, address and phone if different than above):

Father (include name, address and phone if different than above):

Siblings (include ages):

Custody status:                      Lives with: Parent(s) ☐      Guardian ☐      Other:

Emergency contact:                      Relationship:                      Phone:

Referral Name:                      Agency:                      Relationship:

Address:                      Phone:                      Fax:                      Email:

If case management or Waiver requested, please state reasons these linkage and referral services are necessary to help the child/youth remain in the community:

If respite requested, goal of service for applicant:

If respite requested: Overnight ☐      Hourly ☐      Weekdays ☐      Weekends ☐

Please check all that apply:

- ☐ Experienced one of the following in the last 30 days:
- ☐ Serious suicidal symptoms or other life-threatening destructive behaviors;
  - ☐ Significant psychotic symptoms; and/or
  - ☐ Behavioral problems causing a risk of personal injury or significant property damage.
- ☐ Meets criteria for a rating of 50 or less on the Children's Global Assessment Scale currently.
- ☐ Met criteria for a rating of 50 or less on the Children's Global Assessment Scale in the past year.

How long has the emotional disturbance existed: ☐ one year or longer      ☐ less than one year      ☐ unknown

---

### PSYCHIATRIC INFORMATION:

Currently in treatment? Yes ☐ No ☐ If no, what is barrier to treatment:

Clinical Treatment Agency:                      Phone:

Therapist:                      Psychiatrist:

Diagnosis:      Axis I:  
                    Axis II:  
                    Axis III:  
                    Axis IV:  
                    Axis V:

Does the applicant take medications as prescribed? Yes ☐ No ☐

History of past outpatient treatment? Yes ☐ No ☐ Dates and sites of past treatment, if known:

Currently inpatient? Yes ☐ No ☐ Hospital: Admit date: Anticipated D/C date:  
 History of inpatient admissions? Yes ☐ No ☐ Dates and sites of past admissions, if known:

---

**RISK ASSESSMENT:**

History of suicidal ideation, gestures, threats or attempts? Yes ☐ No ☐ Unknown ☐

History of homicidal ideation, gestures, threats or attempts? Yes ☐ No ☐ Unknown ☐

History of threats or acts of violence towards others? Yes ☐ No ☐ Unknown ☐

Please explain any responses marked "Yes" above and address the nature of any risk:

Early warning signs of decompensation:

Child and family have had contacts with the following resources in the past 12 months (check all that apply):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Mental Health Inpatient Unit  | <input type="checkbox"/> Private Therapist                | <input type="checkbox"/> Preventive Services       |
| <input type="checkbox"/> Emergency Room  | <input type="checkbox"/> MR/DD Services                   | <input type="checkbox"/> Child Protective Services |
| <input type="checkbox"/> Community Residence or RTF  | <input type="checkbox"/> Alcohol/Substance Abuse Services | <input type="checkbox"/> Foster Care               |
| <input type="checkbox"/> Mental Health Day Treatment   | <input type="checkbox"/> PINS Diversion                   | <input type="checkbox"/> Group Home or RTC         |
| <input type="checkbox"/> Mental Health Clinic  | <input type="checkbox"/> PINS                             | <input type="checkbox"/> Juvenile Detention        |
| <input type="checkbox"/> Mental Health Case Mgmt.  | <input type="checkbox"/> Probation                        | <input type="checkbox"/> Family Court              |
| <input type="checkbox"/> Currently resides in an institutional placement and has for 180 consecutive days                                    |   |  |
| <input type="checkbox"/> Has resided in an institutional placement within past 6 months and was hospitalized for 30+ days                    |   |  |
| <input type="checkbox"/> Eligible or applying for institutional placement, including a hospital that provides intermediate or long-term care |   |  |

Degree of functional impairments due to emotional disturbance in the following areas:

	None	Mild	Moderate	Severe
Self Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Child exhibits the following symptoms or behaviors that are attributable to an emotional disorder:

	Not Present	Mild	Moderate	Severe
Psychosis (Hallucinations, Delusions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal or Self-Injurious Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood Lability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity/Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oppositional Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical or Verbal Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Criminal Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cruelty to Animals or Fire Setting (circle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inappropriate Sexual Behavior/Acting Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adjustment to Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attachment Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phobias and Fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive/Compulsive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Encopresis/Enuresis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elopement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

---

**SUBSTANCE ABUSE:**

Clinically relevant? Yes ☐ No ☐ Unknown ☐

Current use? Yes ☐ No ☐ Unknown ☐ Substance(s) of choice:

Current Treatment? Yes ☐ No ☐ Unknown ☐ Current Provider:

Past Use? Yes ☐ No ☐ Unknown ☐ Length of sobriety:  
Past Treatment? Yes ☐ No ☐ Unknown ☐ Past Provider(s):

---

**LEGAL INVOLVEMENT:**

History of involvement with PINS, Family or Criminal Court, and Probation? Yes ☐ No ☐

Charges pending? Yes ☐ No ☐ Currently on probation? Yes ☐ No ☐

Please explain any responses marked "Yes" above:

Probation or Parole Officer:

Phone:

---

**FINANCIAL MANAGEMENT:**

Check if applicable: Medicaid ☐ SSI ☐ SSD ☐ PA ☐

Application pending for: Medicaid ☐ SSI ☐ SSD ☐ PA ☐

Does the child have any income of his or her own? Yes ☐ No ☐ If yes, list total amount:

Does the child have any financial resources, i.e. savings, trusts? Yes ☐ No ☐ If yes, list total value:

Please list any financial management needs:

---

**LIVING ARRANGEMENT:**

Is family homeless? Yes ☐ No ☐ Is family at risk of homelessness? Yes ☐ No ☐

Please list current living arrangement, including any current or pending subsidies:

---

**TRANSPORTATION:**

Please list any current transportation needs:

---

**EDUCATIONAL FUNCTIONING:**

☐ Academic functioning below grade level

School District:

☐ School suspensions and/or expulsions

Current School Placement:

☐ Conflict with peers

Full Scale IQ/Date:

☐ Aggressive towards teachers

☐ Other Developmental or Learning Disability ( )

☐ Inconsistent attendance

☐ Special education services (Classification: )

Summary of current school needs, performance and history:

---

**HEALTH CARE:**

Assistance needed? Yes ☐ No ☐ Unknown ☐

Is there a PCP? Yes ☐ No ☐ Unknown ☐ Name: Phone:

Medical Conditions: Allergies:

---

**SOCIAL SUPPORTS/FAMILY FUNCTIONING:**

Community/religious/social supports:

Talents/interests:

Identified support needs:

	Not Present	Mild	Moderate	Severe
Supportive family unable to cope with child's disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent(s) with physical/behavioral health limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling(s) with physical/behavioral health limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parents(s) with active substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk of physical neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk of medical neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk of psychological or social neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk of abuse or violence in home environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

---

Is the child/youth aware of this referral? Yes ☐ No ☐

Is the child/youth interested in services? Yes ☐ No ☐

Is the family interested in services? Yes ☐ No ☐

Please note child/youth and family strengths, skills, and interests:

---

Please add any additional comments:

Required information:

- ☐ Consent for release of information
- ☐ Psychiatric evaluation (most recent)
- ☐ Admission/discharge summaries (recent)
- ☐ Copies of insurance and social security cards

Please send application and required information to:

SPOE Coordinator, Office of Community Services  
230 Maple Street  
Glens Falls, NY 12801  
Phone: (518) 792-7143; Fax: (518) 792-7166

<b>SINGLE POINT OF ENTRY AUTHORIZATION FOR RELEASE OF INFORMATION</b>		Name (Last, First):  DOB:	
This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information in accordance with State and federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.			
<b>Description of Information to be Used/Disclosed:</b> General medical reports, social histories, psychosocial reports, psychiatric assessments, Individualized Educational Plans, psychological testing, other:			
<b>Purpose or Need for Information:</b> The purpose of this disclosure is for determination of eligibility for residential, case management, respite, and psychosocial/vocational programs licensed and/or funded by the New York State Office of Mental Health and overseen locally by the Office of Community Services for Warren and Washington Counties.			
<b>From:</b> Name, Address & Title of Person/Organization/Facility/Program Disclosing Information		<b>To:</b> Name, Address & Title of Person/Organization/Facility/Program to Which this Disclosure is to be Made  The Single Point of Entry Committee (SPOE), comprised of representatives of community agencies including the Office of Community Services for Warren and Washington Counties, the Warren-Washington Association for Mental Health, Behavioral Health Services of The Glens Falls Hospital, Parsons Child and Family Center, Northeast Parent and Child Society, Liberty House Foundation, Voices of the Heart, the Office for Persons with Developmental Disabilities and the Departments of Social Services for Warren and Washington Counties.	
I hereby authorize the use or disclosure of the above information to the Person/Organization/Facility identified above. I understand that: 1. Only this information may be used and/or disclosed as a result of this authorization. 2. This information is confidential and cannot legally be disclosed without my permission. 3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected. 4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing. I am aware that revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization. 5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits. 6. I have a right to inspect and copy my own protected health information to be used and/or disclosed in accordance with the requirements of the federal privacy protection regulations found under 45 CFR§164.524).			
Please select one choice from either B-1 or B-2 B-1. One-time Use/Disclosure: I hereby permit the one-time use or disclosure of the information described above to the person/organization/facility/program identified above. My authorization will expire: <input type="checkbox"/> When acted upon; or <input type="checkbox"/> 90 Days from this Date. B-2. Periodic Use/Disclosure: I hereby permit the periodic use/disclosure of the information described above to the person/organization/facility/program identified above as often as necessary to fulfill the purpose identified above. My authorization will expire: <input type="checkbox"/> One year from this date; If neither B-1 nor B-2 is selected, this authorization will expire one year from this date.			
<b>Patient Signature:</b> I certify that I authorize the use of my health information as set forth in this document.			
_____ Individual (or Child or Youth) (Name)      Date		_____ Individual (or Child or Youth) (Signature)      Date	
_____ If applicable, Parent or Guardian (Signature) Date		_____ Witness (Signature)      Date	

Dear Community Partner:

Please find attached a revised application for Children and Youth Waiver, Case Management, and Respite Services operated by Parsons Child and Family Center, the Glens Falls Hospital, the Warren-Washington Association for Mental Health and Northeast Parent and Child Society, and coordinated locally in collaboration with the Office of Community Services for Warren and Washington Counties.

The primary objective of these programs is to provide linkage and referral services for children with serious emotional disturbance and their families in order to improve functioning in their homes, schools and communities, thus reducing the need for hospitalization or placement outside the home.

The ***Supportive Case Management*** and ***Intensive Case Management Programs*** facilitate mental health and medical service delivery by helping children, youth and families make and keep appointments, advocating on their behalf, and assisting children, youth, and families with gaining access to entitlements and health care services. The ***Home and Community-Based Waiver Services*** program is designed for children and youth who might otherwise be admitted to hospital or institutional levels of care. Services include individualized care coordination, crisis response, intensive in-home, respite care, family support and skill-building. ***Respite services*** provided needed breaks for parent or guardians and children.

A child or youth may qualify for these services if he or she is:

- experiencing a serious emotional disturbance or behavioral disorder;
- at risk of being hospitalized, re-hospitalized, or placed outside the home;
- having difficulty functioning in the home, school and community;
- involved in multiple systems (mental health, special education, family court, etc.);
- engaged in clinical treatment or services which have not been successful; and
- living with parents or guardians who are able and willing to participate in services.

Eligibility for admission to these programs is determined by the *Single Point of Entry (SPOE) Committee*. Provider agencies participate in the committee. Their input helps to ensure that each applicant receives the appropriate level of care to meet his or her needs. Availability of services is limited. There may be a delay in receiving services even after an applicant has been determined eligible. If the referring agent or parent/guardian is not satisfied with the committee's recommendations, they have the right to appeal the decision by contacting this office. However, the SPOE committee and participating programs reserve the right to make the final determination.

The attached referral should be filled out completely. In addition, the referring agent should attach copies of:

- **Signed release of information;**
- **Psychiatric evaluation, including past and present GAF score (*most recent*);**
- **Relevant admission and discharge summaries (*most recent*); and**
- **Copies of Medicaid or other health insurance benefit card and social security card.**

The referral and any pertinent information should be forwarded to:

SPOE Coordinator  
Office of Community Services  
230 Maple Street, Glens Falls, NY 12801  
Telephone: (518) 792-7143 Fax: (518) 792-7166

After receiving and reviewing the completed referral, we will contact you as soon as possible regarding the next step in the process. **Thank you for your interest in our programs.**